## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/18/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріш	LDING	00	COMPL	ETED
15G040			B. WIN			04/24/	2012
NAME OF I	DROLUDED OD CLUDDI IE	D			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R		300 W	53RD AVE		
ARC OF	NORTHWEST IND	DIANA INC, THE		GARY,	IN 46410		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
W0000							
			W <sub>0</sub>	000			
		or the investigation of	WO	000			
	Complaint #IN0	00106372.					
	COMPLAINT :	#IN00106372·					
		TED, Federal and state					
		ated to the allegation(s) are					
		• , ,					
	cited at WIII, V	W192, W331 and W436.					
	Datas of summary	. Amril 19 10 22 and 24					
		: April 18, 19, 23 and 24,					
	2012						
	Facility number	· 000597					
	Provider numbe						
	AIM number: 10						
	Allyl humber. Iv	00233420					
	Surveyor: Chris	stine Colon, Medical					
	Surveyor III/QM						
		AINI					
	The following d	eficiencies also reflect					
		accordance with 460 IAC					
	9.	accordance with 400 17 te					
	<i>)</i> .						
	Quality review	completed on May 3, 2012					
		n, Medical Surveyor III.					
	oy Dony wanoi	n, wiculcai surveyor III.					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000597

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPL	ETED	
		15G040	A. BUII B. WIN			04/24/	2012	
			B. WIN		ADDRESS CITY STATE ZID CODE			
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE			
ARC OF NORTHWEST INDIANA INC, THE				53RD AVE IN 46410				
ANC OF	NORTHWEST INDI	ANA INC, THE		GART,	111 404 10			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
W0111	483.410(c)(1)							
	CLIENT RECOR							
		develop and maintain a						
		ystem that documents the re, active treatment, social						
		protection of the client's						
	rights.	protocaen or and enemic						
	-	ew and record review for	W0	111	Community Services Nurses w	/ere	05/24/2012	
		lients (A), the facility			trained on, assessing clients,			
	•	all pertinent information			reporting and documentation of			
		-			4/27/12. The Service Coordinate	ator		
	_	lient's health was part of			and or Community Services			
	the client's chart/	records.			Nurse will train DSPs on who			
					when to contact, when outside family members/friends call a			
	Findings include	:			ambulance or police officer to	the		
					home.	aio		
	A confidential in	terview was conducted			To ensure future compliance, t	the		
		9 P.M. The confidential			Director of Health and Safety,			
		cated on 3/24/12 while			Services Nurse and the Service			
		nily member, her family			Coordinator will audit/monitor t	-		
	_				three months and as necessar	У		
		she felt dizzy and faint			thereafter.			
		was going to fall. Several						
	_	ade by the client and her						
	family member to	o have the staff address						
	the concern, but	she indicated the staff						
	refused to attend	to the client. The						
		d she had an ambulance						
		group home to assess						
	her family memb	-						
	A marriar - C - 1*	Alamadian Income						
		nt A's medical record was						
		23/12 at 1:30 P.M. The						
		ad notations dated						
	3/21/12 and 4/16	/12 for orders for labs to						
	be drawn. The re	ecord failed to have the						
	results of the lab	tests. Further review						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JEKX11

Facility ID: 000597

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G040	(X2) MULTIPLE CO  A. BUILDING  B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 04/24/2012
	PROVIDER OR SUPPLIEI NORTHWEST IND		300 W	ADDRESS, CITY, STATE, ZIP CODE 53RD AVE IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES SICY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	nursing staff in 1	regards to client A's zziness and faintness			
	on 4/24/12 at 1:4 indicated she co day but she was her sister and he the phone. She was going to fall called an ambula	th client A was conducted 40 P.M. Client A uld not remember what not feeling well and told r staff would not come to said she felt dizzy and l. She said her sister ance but the staff told the did not need them and			
	dated 3/24/12 w 11:30 A.M. The "Dispatched for not feeling well. location was adv services needed sister had called get on the phone	S report #12-0004458 as done on 4/23/12 at report indicated: a patient at this location On arrival at this vised that there were no that the patient (sic) because the staff didn't e and talk to her. Was is location needs medical			
	LPN indicated the been in the medit further indicated	24/12 at 3:20 P.M The he lab results should have ical record. The LPN I there was no n client A's record to			

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PRINTED: 05/18/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION  OF CORRECTION  15G040	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	— COM 04/2	TE SURVEY MPLETED 24/2012
	PROVIDER OR SUPPLIER  NORTHWEST INDIANA INC, THE	300 W 5	address, city, state, zip 53RD AVE IN 46410	CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
TAG	This federal tag relates to complaint #IN00106372.  9-3-1(a)	TAG	DEFICIENCY)		DATE

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Event ID: JEKX11

Facility ID: 000597

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MI	JLTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		15G040	B. WIN	G		04/24/	2012
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					53RD AVE		
ARC OF	NORTHWEST INDI	ANA INC, THE		GARY,	IN 46410		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
W0192	483.430(e)(2) STAFF TRAININ	G PPOGPAM					
		who work with clients, training					
		ills and competencies					
	directed toward of	clients' health needs.					
	Based on record	review and interview, the	W0	192	See tag # 111 p.2		05/24/2012
	facility failed for	1 of 3 sampled clients					
	(client A) by staf	f not demonstrating					
	skills and compe	tency to address client					
	A's health needs.						
	Findings include	<u>.</u>					
	A review of clier	nt A's medical record was					
	conducted on 4/2	23/12 at 1:30 P.M. A					
	review of the stat	ff daily narratives failed					
		ocumentation on 3/24/12.					
	1	cumentation of client A's					
		zziness and not feeling					
	well, and no doci	_					
	1	ng at the group home.					
		ng at the group nome.					
	An interview wit	h client A was conducted					
	on 4/24/12 at 1:4						
		ald not remember what					
		not feeling well and told					
	1 -	a phone conversation.					
	_	staff would not come to					
		aid she felt dizzy and					
	_	. She said her sister					
		nce but when it arrived,					
		n they did not need it and					
		ecking her. When asked					
		•					
		staff checked her vitals,					
	chent A stated "I	No, she watched TV					

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	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	OO	(X3) DATE ( COMPL	
ANDILAN	OF CORRECTION	15G040	A. BUI	LDING	00	04/24/	
		130040	B. WIN			04/24/	2012
NAME OF P	ROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP CODE		
ARC OF NORTHWEST INDIANA INC, THE		ANA INC THE			53RD AVE IN 46410		
					114 404 10		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
1710		confidential interview	+	1710			DATE
	` ′	n 4/19/12 at 1:49 P.M.,					
	and confirmed th						
	and commined in	ns information.					
	A raviant of EMS	S (Emorgonov Modical					
		S (Emergency Medical					
	′ *	#12-0004458 dated e on 4/23/12 at 11:30					
		indicated: "Dispatched					
		at this location was					
		e were no services					
	•	patient (sic) sister had					
		e staff didn't get on the					
	-	her. Was told no one at					
	this location need	ds medical help."					
		1.4.0.					
	An interview wit						
	` '	) was conducted on					
		P.M. The SC indicated					
	group home staff						
		events that occurred on					
		ner indicated staff should					
		ent A. The SC further					
		vas no documentation in					
	client A's record						
	addressed client	A's complaints of illness.					
	_	relates to complaint					
	#IN00106372.						
	9-3-3(a)						
			-				

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PRINTED: 05/18/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 15G040	(X2) MULTIPLE CC  A. BUILDING  B. WING	00	_	
	PROVIDER OR SUPPLIE	DIANA INC, THE	300 W	address, city, state, zii 53RD AVE IN 46410	P CODE	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	CORRECTION N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JEKX11

Facility ID: 000597

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY  COMPLETED
		15G040	A. BUILDING B. WING		04/24/2012
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIEI	R		53RD AVE	
ARC OF	NORTHWEST IND		GARY,	IN 46410	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
W0331	483.460(c)	CLSC IDENTIFTING INFORMATION)	TAG		DATE
***************************************	NURSING SER' The facility must	VICES t provide clients with nursing ordance with their needs.			
	Based on record	review and interview, the	W0331	See tag # 111 p.2	05/24/2012
	facility failed for	r 1 of 3 sampled clients			
	(client A) by not	t ensuring client A			
	received nursing	s services according to her			
	medical needs.				
	Findings include	e:			
	A review of clie	nt A's medical record was			
		23/12 at 1:30 P.M.			
		ecord failed to indicate			
		ion by the nursing staff to			
	indicate an asses				
	completed in reg	gards to client A's			
		zziness and faintness			
	on 4/24/12 at 1:4	th client A was conducted 40 P.M. Client A			
		uld not remember what			
		not feeling well and told			
	_	a phone conversation.			
		ner staff would not come			
	_	ne said she felt dizzy and			
		l. She said her sister			
		ance but when it arrived,			
		em they did not need it and			
	it left without ch	_			
		rview was conducted on			
	4/19/12 at 1:49 l   information.	P.M., and confirmed this			
	inionnation.				

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Event ID: JEKX11

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/18/2012 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number:  15G040	(X2) MULTIPLE CO.  A. BUILDING  B. WING	00 	COMPLETED 04/24/2012	Υ
	PROVIDER OR SUPPLIER  NORTHWEST INDIANA INC, THE	300 W 5	ddress, city, state, zip cod 3RD AVE N 46410	Е	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE COM.	(X5) PLETION ATE
	A review of EMS (Emergency Medical Services) report #12-0004458 dated 3/24/12 was done on 4/23/12 at 11:30  A.M. The report indicated: "Dispatched for a patient at this location not feeling well. On arrival at this location was advised that there were no services needed that the patient (sic) sister had called because the staff didn't get on the phone and talk to her. Was told no one at this location needs medical help."  An interview with the LPN was conducted on 4/24/12 at 3:20 P.M. The LPN indicated there was no documentation in client A's record to indicate nursing staff assessed client A after her complaints of dizziness and faintness.  This federal tag relates to complaint #IN00106372.  9-3-6(a)				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G040	B. WING		04/24/2012
			STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER				53RD AVE	
ARC OF NORTHWEST INDIANA INC, THE		ANA INC, THE		IN 46410	
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
TAG W0436	483.470(g)(2) SPACE AND EQ The facility must repair, and teach informed choices eyeglasses, hear communications devices identified as needed by the Based on observat interview, for 1 of (client A), the fact and teach client A  Findings include  A facility owned was conducted of until 2:20 P.M. Of throughout the cl observed during period not wearin was not prompter eyeglasses.  An interview with on 4/24/12 at 1:44 indicated she did eyeglasses were.  An interview with Professional (DS 4/24/12 at 1:45 Professional (DS)	duipment furnish, maintain in good a clients to use and to make a about the use of dentures, ring and other aids, braces, and other d by the interdisciplinary team e client. ation, record review, and of 3 sampled clients cility failed to encourage A to wear her eyeglasses.  day program observation on 4/24/12 from 1:20 P.M. Client A walked lassroom. Client A was the entire observation ong eyeglasses. Client A d by staff to wear her  the client A was conducted to P.M. Client A on the client	W0436	Service Coordinator will develor and implement a training program for client A to learn to wear her glasses. To ensure future compliance, Service Coordinat will audit monthly.	DATE  05/24/2012  ram r
		hen asked if she wears			

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	OF CORRECTION  OF CORRECTION  15G040	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	— CON 04/	TE SURVEY MPLETED 24/2012
	PROVIDER OR SUPPLIER  NORTHWEST INDIANA INC, THE	300 W 5	address, city, state, zip 53RD AVE IN 46410	CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	her eyeglasses, DSP #1 stated, "sometimes."				
	A review of client #3's record was conducted at the facility's administrative office on 4/18/12 at 11:15 A.M. A review of client A's medical record indicated a most current vision assessment dated 4/26/11 which indicated: "Current Rx (script) is finereturn in 1 year."  An interview with the Service Coordinator (SC) was conducted at the facility's administrative office on 4/24/12 at 3:30 P.M. The SC indicated client A should wear her eyeglasses and further indicated staff should prompt her to wear them.  This federal tag relates to complaint #IN00106372.  9-3-7(a)				

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